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Beyond Patient Satisfaction:
Physician Ambivalence, Authenticity, and the Challenges to Patient-Centered Medicine

A Thesis Submitted to the
Yale University School of Medicine
in Partial Fulfillment of the Requirements for the
Degree of Doctor of Medicine

by

Kiera S. Levine

2008

Abstract

Despite tremendous and increasing clinical opportunities for cure and comfort, patients often still feel dissatisfied in their relationship with their doctor. That patient dissatisfaction has endured, even in the face of increasing medical knowledge and capacity, suggests a failing not in the quality of medical treatment but in the way it is administered. Increasingly, the modern medical movement toward patient-centered medical care (and away from doctor-centered care) has attempted to address this failing, looking to patient-satisfaction as one of its primary measures of success in these efforts. However, its willingness to overlook the importance of the *basis* of reported satisfaction, belies its deeper, if unconscious, aim: to allow doctor and patient to avoid confronting deep-seeded ambivalence that each feels towards the other, inherent in their relationship. The opposing urges constitutive of this ambivalence threaten to reverse physicians' hard-won, positive self-concept, anchored in their sense of beneficence. Faced with this threat, physicians often flee to the seemingly safer psychological territory of strict adherence to professional norms. But far from finding safety in these norms, many physicians feel failed by them and their promise of protection from the harms of deep involvement with patient turmoil. Thus unprotected, physicians often breach these norms in effort to protect themselves. This loss of standing with their sense of professional commitment, however, leaves them feeling further betrayed, now by themselves. Caught between a loss of protection and a loss of standing, doctors often feel disaffected and deeply embattled, as do the patients who bear this outcome. Unable to sustain these complex feelings, doctors often engage the problems of patient care in ways that promise to conceal these feelings. The false premise of this engagement, however, undermines physician authenticity and disables patient-centered care. How then can the doctor be restored to the feeling of authenticity he/she needs to stay with his/her patients in the midst of the tremendous and tremendously evocative ambivalence posed by serious illness? If physicians are unaware of the negative counter-transference that is activated in such evocative circumstances, they will be unaware of the danger that the treatment plans they pursue aim at least as much at self-protection as at patient care. This is the loss of patient-centeredness wrought by physician inauthenticity. Thus, this thesis contends that the deeply ambivalent feelings that commonly trouble physicians, far from requiring suppression, ought to have a role in the care of the patients they are thought to threaten, if the doctors who have them are to be restored to themselves and so, too, to the patients depending on them.

Acknowledgments

This thesis was undertaken as a means of exploring several of the issues that have interested me most in these last five years that I have been a medical student here at Yale. These interests have grown primarily from several particularly moving experiences that I had on the wards (on the neurosurgery, general surgery, and pediatric oncology services), observing doctors and patients struggling within themselves and with each other about how to actualize respectful and responsible medical care. Inspired by the richness of these struggles, I wanted this thesis project to be more than the fulfillment of a school requirement and, instead, to help me enter into a life of thinking about the culture of medicine. I feel extremely thankful for the encouragement, guidance, and inspiration that I received from my primary thesis advisor, Professor Robert A. Burt, of the Yale Law School. To me, he is one of the most interesting, honest-minded, and courageous thinkers I expect I will ever meet, and my discussions with him were often altogether illuminating. I also wish to acknowledge my medical school thesis advisor, Dr. Thomas P. Duffy, whose deeply supportive mentorship, sensitivity, and intellectual energy I felt lucky to benefit from. I feel enormous gratitude toward each of these two teachers for having given me so much. I also wish to thank Professor John Warner, in the Department of History of Medicine, as he was the first faculty member that I approached when I began thinking about my thesis topic two years ago. Though I was concerned that my ideas were too undeveloped and too many for a faculty member to bear, I was relieved and comforted that Professor Warner received them all warmly and with encouraging attention. His openness and humanity toward young scholars and the challenges they face are treasures in this medical school community. I would also like to recognize Jan Glover of the Medical Library, whose assistance in preparing the references was a wonderful help. Also, I would like to acknowledge the Office of Student Research for their financial support of this thesis. Humanities research is often difficult to describe and therefore difficult to fund, but I have received all the funding that I requested and I am very appreciative of their faith. Finally, I wish to thank my partner, Ana, whose love and depth gave me the energy I needed to make of this thesis what I wanted.

Table of Contents

1. Introduction (p. 1)
2. The problem with the standard of patient-satisfaction in patient-centered care (p. 2)
3. From self-deception to self-honesty: exploring the basis for satisfaction (p. 9)
4. Ambivalence and what its recognition promises (p. 20)
5. Ambivalence and the call for authenticity (p. 22)
6. The problem of authenticity (p. 24)
7. Negative countertransference: when clinicians hate their patients (p. 27)
8. The preference for false conflict and a way through it (p. 34)

References

1. Introduction

Despite tremendous and increasing clinical opportunities for cure and comfort, patients often still feel unknown and dissatisfied in their relationship with their doctor. That patient dissatisfaction has endured, even in the face of increasing medical knowledge and capacity, suggests a failing not in the quality of medical treatment but in the way it is administered. Disentangling the many roots of this dissatisfaction is a complex task. In *The Silent World of Doctor and Patient*, Jay Katz examines the substantial contribution that psychological forces make to that complexity, “The complexities inherent in the practice of medicine, in the conflicting motivations that physicians bring to their interactions with patients, and in the conflicting needs that patients bring to their interactions with physicians defy...simplistic notions” (1 p.229).

Comments like this one are part of an enormous literature pertaining to the paradigm shift still underway in modern medicine from doctor-centered medical care to patient-centered care. The history of this metamorphosis is also complex, but it essentially rests on the medical establishment’s collective decision to recognize an earlier well-intentioned but wrong-headed and often ill-fated culture of medical care that was driven by physicians’ unquestioned expert estimation of patient illness and presumed altruism devoted to upholding patient well-being. The movement away from this paternalism began with the prioritization of a variety of principles that are now viewed as bedrock values of the field: informed consent, full disclosure, confidentiality, and patient autonomy.

More recently, this movement has recognized the way that the macro-culture of medicine is shaped by the micro-culture that exists between a single doctor and his/her patient. Patient-centered care, as it is currently conceived in the literature and medical education, is concerned as much with the way things are said between doctor and patient (i.e., which words or tone to choose to create a certain emotional effect worth establishing) as with why they ought to be said (i.e., in

the fulfillment of which principles). The shift from doctor- to patient-centered care has been formalized, awkwardly so some have argued, in a variety of medically-mainstream algorithms and injunctions intended to ensure the priority of the patient's personhood: 6 steps to communicating distressing news to a patient (2), how to use phrases like "uh-huh, go on" and "tell me more" to ensure proper solicitation of a patient-centered history, how to use the 5 A's (assess, advise, agree, assist, arrange) to help patients take better care of themselves, how to NURS patients' emotions (Name, Understand, Respect, Support) (3). Despite how simplistic such techniques may appear, many physicians have benefited from their support, and important improvements in patient health outcome and satisfaction with doctors' care have been documented. In fact, according to the 2006 National Healthcare Quality Report, the percentage of patients reporting poor communication with their doctors has decreased to less than 10% this year (4).

The data is heavily conflicting, though, and many studies report that the opposite is true: doctor-patient communication is worsening (5). Looking into the determinants of patient satisfaction with their relationship with their doctor reveals many intriguing details. Consider the finding that increased patient satisfaction is correlated with *negative* physician affect (6). Or that patient assertiveness is correlated with *decreased* patient satisfaction (7). Or that anxiety and depression attributed to hospitalization is correlated with *increased* patient satisfaction (8). Together with the vastly conflicting data, details like these force at least this question: what is the basis for a sense of satisfaction? What are the roots of such unobvious determinants of patient satisfaction as negative doctor affect? The answer to these questions may be particularly instructive in our efforts to repair the inadequacies of the modern doctor-patient relationship. The discovery of that answer is the primary concern of thesis.

2. The problem with the standard of patient-satisfaction in patient-centered care

Before proposing an answer, the complexity and pervasiveness of conflicting and counterintuitive findings is worth beholding. In many studies, patient satisfaction has been linked to the provision of adequate information by the physician (9). However, other studies have shown that what is gleaned from this information is tremendously variable, calling into question what is meant by ‘adequate information.’ In a study comparing what patients perceived was told to them by their oncologist and what the oncologist perceived he/she had told the patient, a very surprising finding resulted: only approximately 60% of the patients whom doctors reported had been informed of their cancer diagnosis, agreed that they had been so informed (10). As the study explains, “It could, of course, be said that this finding relates to a common mechanism of denial in the patients. However, less than 50% who were told they were free of cancer agreed they had been so informed.” Thus, while patients seem to derive satisfaction from receiving information, it is difficult to determine what information is being given to them and how it is being received. One study investigated this conundrum by evaluating patient satisfaction when doctors attempted to meet a patient’s explicit request for certain forms of information (diagnosis, prognosis, etiology, treatment, social effects of illness). But, at least according to this study, patients whose doctors correctly assessed the kind of information they wanted reported no increase in satisfaction compared with patients whose doctors incorrectly judged their information needs (11). Thus, the enigmatic circle of data proceeds in this way: patients are increasingly satisfied when they receive the information they want, but that information cannot be reliably supplied, and even when adequate information is approximately well supplied, patients do not report increased satisfaction. Comprehending the meaning of data like this—especially in light of the many substantial variables that makes every study unique (not to mention the uniqueness of each living contributor to each datapoint within a study) and threaten the generalizability of every study’s findings—can be maddening.

Indeed, sifting through contradictory data is one of the defining challenges of understanding the literature on patient satisfaction. The following examples illustrate this

challenge. In one study, patient demographics is reported to have little bearing on patient satisfaction with their general practitioner (12); in another study, patient demographics are reported to have near total bearing on patient satisfaction (13). In particular, female gender is reported variably to correlate with patient satisfaction, as is socioeconomic status (14, 15). Some studies report patient satisfaction is correlated more tightly with the doctor's capacity to communicate well and give support than with the doctor's technical expertise (16, 17); other studies report the opposite (18). Some articles attempt to focus on the microelements of the doctor-patient encounter and discover degrees of satisfaction generated in each of these micro-moments, but the attention to these details fails to penetrate the conflicting data. One study, for example, recorded a series of doctor-patient encounters and coded each verbal event (even laughter, sighs, expletives, fragments of speech, tone, etc.) according to who said it, when it was said in the course of the appointment, and the category within a pre-established taxonomy it represented in order to analyze specific moments within a specific doctor-patient interaction. Findings showed that, in the course of describing one's history of present illness to a physician, patients report increased satisfaction when they have the opportunity to clarify, confirm, or repeat information to their doctor (19). They are also increasingly satisfied by the opportunity to give "non-lexical utterances ('mm-hm') or countless [lexical] utterances ('yes', 'no', 'hello')." But time used to talk with a patient about his/her history has been variably correlated with patient (dis)satisfaction. Data describing how doctor and patient questioning is related to patient satisfaction is also conflicting. While patients' requests for medications early in a doctor's appointment has been correlated with increased patient satisfaction, requests made later in the appointment is correlated with decreased satisfaction (7). Not only are the data inconsistent, but seemingly every moment in a clinical encounter can be captured as an opportunity to garner satisfaction. For two agents, doctor and patient, hungry for satisfaction when confronting the possibility of illness and all the turmoil that illness signifies, the view that each moment in the course of an encounter can be mined for opportunities to win satisfaction must certainly be

attractive. But what underlies this hunger for satisfaction? What is at stake in research that functions by means of this hunger without awareness of it or its basis? These questions are critical for reasons that will be addressed later in this section. For now, however, in the previous study, regarding the request for medications, while researchers admit that the dizzying number of findings should really be used to generate broader hypotheses about patient satisfaction, they nevertheless suggest that “physicians may find it useful to make an opportunity in the encounter process for patients to request medications at a relatively early stage. The timing of this patient behavior appeared to be critical to subsequent patient satisfaction with the encounter.” This suggestion is stunning for the commitment to mining for opportunities that it reflects.

Contemplating the incorporation of innumerable similar suggestions into the average clinical encounter is exhausting, but more importantly, it misses the point that satisfaction is not something to seek in itself, but something that should result authentically and inadvertently from a deep pursuit of patient understanding. So distressing is the possibility of patient dissatisfaction that one study, looking at family satisfaction in the ICU setting when faced with decisions about withdrawal of life support, states that “limiting conflict...[is] morally imperative” (20). The concern for satisfaction in such treacherous settings as the ICU is of course, understandable. But the concern this paper has is with the possibility that the pursuit of satisfaction, the moral imperative to avoid conflict wherever possible in pursuit of satisfaction, will have deeper patient (or patient family) concerns, hopes, fears, and feelings go totally unnoticed—and ultimately unhonored. As this paper will explore in greater detail later, certain key feelings come out only in conflict. If that conflict is not received and managed well, then no therapeutic value will be derived from the discovery of the feeling, and in fact harm may be done. The problem there, though, is not with the eruption of conflict, but with its poor management and the harm that usually results. The “moral imperative” is to limit the harm, not the conflict. In fact, if conflict is managed well, the partnership between doctor and patient can be deepened immensely and the acknowledgement of patient’s personhood can be nothing short of profound. Avoiding conflict

sells out on this potential. The work in pursuit of satisfaction never arrives at these depths and can never deliver an outcome as important. As this paper will argue, it also betrays the fundamental aims of patient-centered care.

To understand the problems of pursuing patient satisfaction as a way of realizing the goal of patient-centered medicine, it is useful to explore the relationship between patients' satisfaction and doctors', as well. How much does doctor satisfaction with their patient interactions and treatment outcomes hinge on patient satisfaction, despite the possibility of its distorted basis? Some studies have found tight correlations, going so far as to propose arithmetic equations that describe how doctors and patients can experience a mutually satisfying clinical encounter: Encounter Satisfaction = Acknowledgement + Anticipation + Experience + Expectation + Explanation ($ES = 2A + 3Ex$), (21). A less abstract description of this correlation is offered in a recent study by the Brigham and Women's Hospital, reporting that patients of doctors who describe themselves as extremely satisfied professionally tend to be more satisfied with their overall healthcare than patients of less satisfied doctors (15). Another study, from a collaboration between Oregon Health Sciences University, Portland State University, New York University, Cincinnati Children's Hospital, and the Robert Graham Center for Policy Studies in Family Medicine and Primary Care in Washington, D.C., looked at a range of variables associated with doctor and patient satisfaction. The two variables most tightly correlated were physician overall career satisfaction and their patients' satisfaction with overall healthcare (22). The measured variables were substantial and pertained to several well-known elements of a satisfying doctor-patient relationship: physician sense of clinical decision-making freedom, the ability to provide high quality care, being able to avoid sacrificing income in the pursuit of high quality care, patient satisfaction with their choice of physician, and patient trust that their doctor prioritizes quality care-giving over everything else. One might have reasonably predicted that the tightest correlation would occur between the physician's sense that he/she is able to deliver high quality care and the patient's sense that he/she chose the right physician, but this is not reflected in the

data. The data shows that the tightest correlation is between two much less well-carved out variables, two senses of “overall satisfaction.” What is to be made of this correlation between such sweeping forms of satisfaction? The concern this paper has is in the possibility that much lives in the vagaries of this correlation. Even if one form of satisfaction is not causally linked to the other, the linkage is significant: there is a cycle of mutually reinforcing satisfaction between doctor and patient that just as well could spin in the direction of dissatisfaction. One important claim this paper is committed to is that the medical community should be careful not to lose itself in the work of pushing the cycle in one direction over the other, but instead devote itself to understanding *the basis* of the linkage; without that understanding, even if a cycle of mutually reinforcing satisfaction could be set in motion, it is possible that the basis for a given doctor’s or patient’s satisfaction is distorted, a psychological injury seeking alleviation as expeditiously as possible, even if that means inadequate longterm redress, even if it comes at the expense of important values in appropriate medical care. If the deeper basis for one’s sense of satisfaction is relief from injury or distress, thirsty pursuit of satisfaction may conceal a cycle of reinjury that, once in place, can create cyclical opportunities for alleviation that may be read as satisfaction, but hardly a form of satisfaction most would want to encourage (i.e., one that depends on continual reinjury).

Despite all this conflicting and counterintuitive data, studies pertaining to patient satisfaction continue, of course. Beyond the aim of ensuring patient-centered care, there are many reasons why satisfaction has become such a focus of research. Many studies have shown that patient satisfaction is correlated with patient compliance with treatment and loyalty to a particular care provider (23). Other studies cite the relationship between increased patient satisfaction and decreased malpractice claims; in one study, inpatient physicians whose patients were least satisfied with their performance had malpractice rates 110% higher than physicians whose patients were most satisfied (24). Ensuring patient satisfaction, therefore, has been promoted as a strategy to minimize the number of malpractice lawsuits. Marketing companies

have commodified patient satisfaction, studying which emotions experienced by patients contribute most to the feeling of satisfaction and what can be done to urge the surfacing of those patient emotions that are positively correlated with satisfaction and doing so during the moments when satisfaction is most sensitive to the influence of those emotions (8). Of course, these other uses for data on patient satisfaction do not, in themselves, make research on patient satisfaction altogether wrong (though, to be sure, its transparency is threatened); they do, however, highlight the ways in which the pursuit of patient satisfaction casts the patient as an object of manipulation, used by business to secure profitability or by doctors to derive a sense of beneficence or relief from guilt.

The central thesis of this paper, then, is that patient satisfaction is the wrong standard for determining the success of patient-centered medical care: it is dangerous, casts the patient as an object by means of which a standard of care is achieved, and ultimately it abandons the patient to struggle alone with his relentlessly competing desires for satisfaction. Indeed, these competing desires may well explain why data regarding patient satisfaction is so rife with contradictions and inconsistencies: because this deep-seated psychological ambivalence lives inside of each of us, even when one is asked to declare him/herself decisively as satisfied or dissatisfied. Lived experience, it is well-known, is more complicated than these simple statements of satisfaction suggest: important forms of patient dissatisfaction (e.g., disappointment, resentment and fear) are alive even in seemingly manifest satisfaction, just as important forms of satisfaction (e.g., a sense of importance, relief from guilt, discharge of anger at succumbing to illness, feeling alive) live inside of manifest dissatisfaction. This complexity may never be eliminated, much as we may wish it would for the purposes of giving cleaner study results. Satisfaction may, ultimately, be impossible to assess in any meaningful way because it is the basis of satisfaction that determines its meaning, and the *basis* of satisfaction is not attended to by ordinary research tools. Of course a more superficial assessment of patient satisfaction can be made, but it does not signify what most physicians hope it would—namely that the patient's unique humanity has actually been

noticed and our respect for its struggle with ambivalence is as deep as for our own. The accomplishment of noticing and respecting is vulnerable to self-generous, simplistic estimations made by physicians hungry for approval and habituated to converting things as complicated as acquiring informed consent into a checklist of tasks. But to carry out care that is authentically patient-centered, physicians need to let go of the self-soothing, comfortably concrete work of discovering the correlates of patient satisfaction, and take up a much more complex task, which begins with accepting the profundity and inescapability of our pervasive internal ambivalence.

3. From self-deception to self-honesty: exploring the basis for satisfaction

What is our struggle with ambivalence? How can it be described? Anna Freud, in an address to the entering class of Western Reserve Medical School, in 1964, described at least one form of it that physicians harbor in this way:

In every nursery school, the nursery school teacher is prepared that in some corner of the room, or of the garden if there is one, a hospital will be established, and this hospital will be usually for insects, frogs or lizards or any other small animals that can be found. And these small animals will be tended carefully in boxes, fed and looked after and, as the child says, cured. Sometimes, especially when it is an insect, legs will be pulled off beforehand so that a patient is produced, and the patient is cured afterwards. Which means that the child's wish to help and to cure is still very close to the wish to hurt and to maim. The younger the child, the stronger his wish to hurt. The older and more socially adapted he becomes, the more this aggressive wish can be submerged under a strong urge to help. Both wishes can lead the growing individual straight into medicine. Naturally, no need for the doctor anymore to provide his own patients by harming them. Fate does that for him. He only needs to cure them. But the wish to deal with those who are hurt, in pain, maimed has to be there, and probably always underlies, even though hidden in the unconscious, the wish to cure and to help (25 p.643).

This statement is particularly interesting to consider in the context of the previously mentioned findings that show a tight linkage between doctor- and patient-satisfaction. Recall that, in the study from Oregon Health Sciences University, Portland State University, New York University, Cincinnati Children's Hospital, and the Robert Graham Center for Policy Studies in Family Medicine and Primary Care in Washington, D.C., the tightest correlation among measured

variables was between physician overall career satisfaction and their patients' satisfaction with overall healthcare. Recall that more tightly contoured variables were measured, but it was between the two most loosely fitting ones that the tightest correlation was found. The primary concern this paper raised pertained to all that can be hidden in terms (like "overall satisfaction") that summarize too much. The preoccupation with drawing on the power of the linkage between doctor- and patient-satisfaction, without regard to the source of their satisfaction, in order to advance the spread of satisfaction from doctor to patient and back again, while appealing, is also dangerous because it is the *basis* of satisfaction that determines the value of achieving it, and that is unexamined in these studies. Without understanding the basis for the satisfaction measured, drawing on the linkage between doctor- and patient-satisfaction can inadvertently (at least consciously so) exploit a psychological deficit, injury, or even an innate malevolence in either party. It is here that this statement by Anna Freud becomes particularly illuminating: it speaks to one form of what may be called innate malevolence—the desire to hurt and to maim. As Anna Freud explains, it starts in the earliest moments of life and, particularly in those earliest moments, may as likely be directed toward oneself as toward another. "There is, in the beginning," as she says earlier in this same speech, "even no barrier to self-injury and the baby would draw blood from his face if the mother did not see to the cutting of his nails. What we call the pain barrier is established gradually during the first year and the child's aggression deflected with it from its own body to the outside world" (25 p.636). With age, she says, these desires become buried beneath an obviously more socially acceptable urge to help, but as with biological development, in psychological development also primordial origins shape, limit, and continue to inhabit mature ones. At the very least, then, by virtue of their shared origin, the urge to help and to cure is inseparable from the urge to hurt and to maim; the wish to hurt may be—and hopefully is—subdued,^{*} but never eliminated. Acknowledging this wish, that it continues to live into our

* "Subdued" is critically different from "submerged," the word Anna Freud actually uses. "Subdued" suggests that one is conscious of its existence, thus not inclined to expend vital energy in its denial, thus reserving vital energy for its well-

maturity, and furthermore that it does so even inside an urge to do the exact opposite—to help and to cure—is critical. Without this acknowledgment, we disable our capacity to detect when satisfaction is derived from the gratification of one of these urges versus the other—a dangerous disability. Appreciating the importance of this capacity is totally missed in measures of overall satisfaction. Though not consciously experienced as satisfying, maybe fulfillment of the desire to harm is part of what underlies the willingness of a doctor to prescribe a medication of questionable necessity, for example, or forgo a treatment that seems important. Anna Freud's comments here point to the uncomfortable fact that key forms of satisfaction live inside even those experiences that many would describe as decidedly dissatisfying. Of course, there may be many other reasons a doctor might prescribe a not-totally-necessary medication or forgo a treatment, but it is of special importance to recognize the potential contribution that our unconscious urges make to such everyday behaviors as these. There are many examples of urges that yield deep satisfaction unacknowledged in consciousness, and that are in fact consciously experienced as dissatisfaction. Consider the patient who arrives at the emergency room, agitated and combative. The resident assesses that the patient is either intoxicated or withdrawing from an addiction. His combativeness continues, and the resident becomes overwhelmed and frustrated with the persistent disruption, interference, even assaultive behavior. In his frustration, he decides, rather than to admit him, to have him arrested. Here the all-too-conscious urge to punish coincides with the possibility of the patient's desire to be punished. This is to say that maybe the patient's behavior in the emergency room is just the most recent permutation of a lifetime of turmoil that in fact is sustained by the patient's sense that he deserves only turmoil. Maybe the patient uses the turmoil to relieve himself of the guilt he feels for failing his own or others' expectation for himself, accepting—even seeking—punishment. This relief from guilt by means of self-punishment is repeatedly fulfilled by his addiction. The inadequacy of this redress—addiction, while certainly punishing, never adequately quenches his thirst for punishment and, in

management. "Submerged" suggests the opposite.

fact, often deepens it—is not incidental, driving a continual renewal of opportunity to self-punish and relieve. Here is the cycle of reinjury that the unconscious doctor advances when he decides to arrest the patient for his assaultive misbehavior. The force of the doctor’s contribution to this injurious dynamic is reinforced by the work it takes for him to overcome the urge to discharge the way the patient seems to allow himself. Maybe the decision to arrest instead of admit is the doctor’s attempt to reach for a more socially acceptable, if problematic, form of striking back at the patient for his misbehavior and halting the patient’s indulgence of an urge that the doctor shares with him (i.e., the urge to assault). The target of the urge is different (for the doctor, the target is a frustrating, even dangerous, patient; for the patient, it is the authorities that, if provoked, will enable him to regain relief through the punishment they administer) but the urge is similar. The urge to be punished provokes and meets the urge to punish, though neither is consciously acknowledged; in fact, far more likely, both are consciously, emphatically, and understandably denied. At the level of conscious awareness, dissatisfaction prevails: the patient does not enjoy being arrested, and the doctor does not enjoy having his patient be arrested. In fact, consciously, both wish for the opposite. These conscious feelings are real, but their reality serves to protect both of them from recognizing what they would regard as too ugly an underworld of urges to tolerate its contribution to their self-concept. These examples are coarsely described here, but they illustrate the point that the conscious experience of satisfaction or dissatisfaction is not as easy to read as one might hope.

The urge to help may sound more innocent than the urge to harm, but unless it coincides with a *need* to help, its fulfillment may be just as dangerous. Consider, for example, when the doctor’s urge to help matches up with the patient’s urge to be helped, even in the absence of any such need. Examples of this dangerous matching are common. One such example is the pervasive practice of prescribing antibiotics to patients who often have viral infections. Here, the urge to help and the urge to be helped motivate a harmful encounter that is experienced as anything but; despite whatever misgivings physicians may have, mutual satisfaction usually

prevails. The key point here is that while satisfaction may indeed be the prevailing feeling, mutual exploitation and injury may be the avenue to it.

These examples illustrate how no form of satisfaction is pure, and this is so because the basis for it is so complex and mired in opposing urges. Conscious dissatisfaction can disguise and make tolerable important but uglier forms of satisfaction that we would rather not admit. Conscious satisfaction can be derived from experiences that sustain injurious cycles that are ignored in the thirsty pursuit of mutual satisfaction. Equally possible, conscious satisfaction can be used to enable the submergence of deeper forms of dissatisfaction, a less pleasant feeling that threatens to create a less pleasant self-concept. Consider the example of a very pleasant but sick patient who readily accepts his doctor's diagnosis and advice and quickly offers summaries of his feelings that seem totally reasonable, even admirable, to the doctor listening to him. On the surface, the patient appears mature, capable, maybe even noble. The physician may feel gratified, relieved, present, maybe humbled. These feelings are real, and in that moment they are powerful. However, it is in the basis of these feelings where the story lies. One possible scenario might be that the patient wants to make his doctor feel good in order to relieve him of the burden of the guilt he may feel that comes from knowing, on some level, that he enjoys the fact that he has been spared his patient's fate. The patient wants to relieve his doctor of this guilt because he needs his doctor desperately. Knowing that the doctor does not share his fate and that the doctor has many other patients who compete for his limited resources, the patient knows that his hold on the doctor's attention is fragile, that his doctor's attention is supplied voluntarily and as such may also be withdrawn. This fragility is made more fragile still by the patient's competing (usually unconscious) urge to reject the doctor's help; the patient's dire circumstance permits the doctor the opportunity to indulge a taste of self-aggrandizing devotion, which the patient resents and mistrusts but tolerates in order to gain the much-needed benefits of the devotion. The power of the connection that the doctor feels with his patient, as he listens to the patient generously summarize his feelings about his diagnosis, is fueled as much by relief that the patient is not

consciously holding him accountable for his failed health as by the doctor's energetic submergence of guilt for his feelings of relief that he does not share his patient's fate. There are other more positive aspects of the powerful connection doctor and patient feel toward one another, but these deeper, less pleasant feelings are often ignored (i.e., submerged) because they threaten the stability of a positive self-concept. For many obvious reasons, the doctor does not want to think of himself as self-aggrandizing, using the patient's misfortune to emphasize his relative safety; neither does the patient want to experience himself as a cumbersome, resentful object, used by the doctor to sustain his view of himself and fated to die alone. The surface of the doctor-patient interaction here is placid, but understanding what lives beneath the surface illuminates the superficiality enabling the simple feeling of mutual satisfaction, and in doing so, questions its relevance in patient-centered care.

There are innumerable sources of ambivalence underlying the doctor-patient relationship, and, this thesis claims, each undermines the relevance of patient-satisfaction as a measure of patient-centered care. One form of ambivalence deserves specific mention here, given its prominence in the experience of being a patient and, because of that, how powerfully it questions the relevance of measuring patient-satisfaction: the desire to be spared. Before exploring the ambivalence that inheres in this desire, an exploration of the context for its emergence is useful. Even in the most ordinary of doctor-patient encounters, routine check ups, etc., it hardly bears mentioning that patients feel anxious about having to be examined by a doctor. While many patients acknowledge their anxiety, the roots of this anxiety often lie beneath the level of their conscious awareness and as such are experienced only dimly and often in disguise: as the tension a patient feels in the doctor's waiting room or in his hospital bed or as his inability to comply with a medication regimen or as his tendency to postpone a needed appointment and so on. Whatever concrete reasons he may be able to cite for these feelings and tendencies, none of them captures the fullness of the anxiety that accompanies them. Still, the apparent legitimacy of these rationales obscures their superficiality and constitutes a powerful surface tension that overlies and

protects the patient's deeper feelings from exposure to the destabilizing forces of open analysis. To breach that surface tension and gain access to some measure of these depths, consider the following (if speculative) thought exercise: a patient arrives at his doctor's office to discuss the result of his recent blood test. Maybe his mindset on arrival is that the news will be good—he feels well and is optimistic; or, maybe he senses bad news, regretting certain high-risk behaviors he has exercised in the past, for example, or remembering the number of close family members who suffer from a particular ailment, which contributes to a sense he has of being predisposed. It is also common that positive and negative mindsets, alike, work as a function of superstition to guard against bad news or as a psychological safeguard against the possibility of *unexpected* bad news. However unaware of these strategies he may be, each of them is built to answer the challenge posed by two more deeply-situated and captivating possibilities: that he is mortally sick or that he has managed to evade mortal sickness. This latter possibility preserves for the patient the hope that there has been a special exception made to the universality of the fantasy of personal indestructibility^{**}: that in his particular case, he really is indestructible, that for him this is no fantasy, and that he will, therefore, continue to avoid debility (including the gravest debility of all, death). On a conscious level, of course, the patient may deny this hope, viewing it as childish, and understands that he may indeed be sick. But consciousness is no safer territory to explore than unconsciousness, particularly when it is given to contemplating the possibility of illness. To attend to the conscious anxiety that he may be sick, the patient chooses to rely on his doctor, an uncomfortable decision considering the force of his countervailing (though usually unconscious) hope regarding his exceptionality. Having so chosen, however, he must be bewildered by the tests his doctor deems necessary. Even if the doctor explains the rationale for these tests, the patient must face the bizarre reality that his fate will become evident through the reading of microscopic, alien entities, like blood cell counts and tumor markers. He must also

^{**} "...at bottom no one believes in his own death, or, to put the same thing in another way that in the unconscious every one of us is convinced of his immortality." From Freud S, "Thoughts for the Times on War and Death," 14 Standard Edition of the Complete Psychological Works of Sigmund Freud (London: Hogarth Press, 1957), p 289.

face the reality that he, himself, cannot decipher the meaning of these markers. This emphasizes his reliance on his doctor, and it can easily foster a sense in the patient that his doctor is endowed with special powers—to decode obscure data; to derive meaning from numbers, words and images that to the patient are meaningless; to restore orientation to the patient otherwise lost to disorientation. Witnessing the doctor's comfort with awkward, seemingly magical markers of wellness, the patient must wonder, however unconsciously, 'How can it be that I have been exiled so from matters of my own wellness? How can so much within and about me be so invisible to me, and so readily visible to someone else?' These questions must gain special force in light of the awful fact, however unacknowledged, that one's sense of feeling well may stem from, in fact, being well or from being merely asymptomatic but in fact quite sick. On some level, the patient must realize his incapacity to distinguish between these two possibilities, which only emphasizes further his reliance on the doctor to do so for him. The patient thus arrives at the doctor's office full of this incredulous, reluctant, hopeful (i.e., psychologically saturated) acceptance of his dependence on his doctor, and it is out of this context that the desire to be spared and the ambivalence contained therein can begin to be understood.

However extreme (and so, unlikely) the anxiety in this desire may appear, its existence is quickly discovered in the patient's stated interests. What he usually wants to know from his doctor is plainly if he is sick and, if so, how sick. But what happens when the doctor answers these questions? When the doctor informs him that he is indeed sick and seriously so, has the patient's question really been answered—or has the anxiety underlying the question merely been laid bare? If, on the other hand, the doctor informs the patient that he is well, again it seems too simple, if superficially accurate, to assess merely that the patient's question has been answered. The pronounced relief, the momentarily profound feeling of wellness, that most patients feel in being so informed belies what was at stake for them when they first posed the question (if only to themselves). An answer, regardless of its content, seems to trigger so many more and deeper feelings in the patient than merely that of being informed that one wonders if his stated question

really seeks only the information that it claims to seek. The possibility that there is something more that interests the patient, beyond the explicit claims of his question, gives hint of his underlying anxiety. This is not to say that his stated question is somehow wrong; it is of course an important question with an important answer. But its formulation seems to search for an answer that would collude with its unstated (unconscious) interest in reshaping the encounter between doctor and patient from one of existential implications to one merely about information, data, and statistics. Therefore, little of the discussion about such information, data, and statistics addresses the patient's deeper anxiety, but this anxiety finds expression, nevertheless, in the patient's persistent concerns; he wonders if the data is real or mistaken, if the information is fixed or available to interpretation, if the more likely or less likely side of a given statistic applies to him (e.g., if 1 in 5 patients do well with a given treatment, this particular patient certainly identifies more with the '1' or the '5'), if his place in the cited statistics would change if his care were managed by a different (i.e., better) doctor. These uncertainties are common and interest in addressing them is understandable, but their basis is far deeper than discussion aimed at answering them suggests. The problem the patient faces, ultimately, is not just that these questions lack simple answers, but that their answers are often conflicting and disappointing. Consider the desire to be spared, which this thesis contends is the basis for the anxiety that these uncertainties reflect, the basis for the other feelings that accumulate around the answer to the question about whether or not he is sick. The patient arrives at the doctor's office wondering if he will be spared, but the existential challenge posed by this question is overwhelming and disorganizing, which fosters his focus on less emotionally charged versions of this question that seek less emotionally charged information. But even if the patient could allow himself to ask whether or not he will be spared, neither answer, yes or no, escapes deep disappointment—and this is the essential ambivalence of the desire; the question itself reflects the patient's recognition that he may not be, that he hopes for mercy in a world that often does not grant it, that his world is not benign in this way, and that his sense of feeling at home in this world (however much he

may have worked to secure it) is thus questioned. Interest in eliminating this disappointment and the fragility it produces motivates the patient to check the status of his wellness relentlessly—or not at all, as is the case with patients who minimize their need for health maintenance in the form of not scheduling or missing appointments, not adhering to medication regimens, etc.; relentlessly checking and refusing to check are both invested in testing the mercy of the world towards the patient's desire to be spared, the former obviously so and the latter by essentially claiming that a truly merciful world would not require such vigilance from the frail. Even ordinary degrees of concern with one's health are defined by the abiding sense that the question of whether or not one's health status is secure is never adequately answered; it is continually searching for reaffirmation. So urgent is the need for reaffirmation, even patients assured of their current good health or of cure cannot help but wonder if the result is real, if it can be trusted (i.e., 'sure, I'm okay know,' the patient asks, 'but how about now? ...and now?'). An answer to the question in one moment fails so completely to answer the question when it spontaneously resurfaces a moment later that it often feels altogether irrelevant. Revisiting the study by Mosconi *et. al.* (mentioned above), one wonders if the patients who denied being informed of their health status—even when they were being told that they were in good health—were trapped in this almost obsessive search for reaffirmation; it is not that they were unable to hear or accept the answer, but rather that their question resurfaced and demanded another answer—and that answer they were not given.**

** A relevant childhood correlate relates to a child playing peek-a-boo. He derives enjoyment from the relief of watching the security and love, embodied in the interlocutor's face that has apparently disappeared, be restored again and again each time the caregiver flings her hands open to reveal a smiling, familiar face. With the revelation, the anxiety that all security and love have disappeared, leaving the child alone and vulnerable, is relieved. The game is interesting to the child as long as the child never quite trusts that the face (and the security that the face embodies) exists when it isn't readily visible: the relief of real tension is what drives the child's engagement. That the child comes to understand that the face is there, even when hands hide it, reflects a step in development that is critical to the child's sense of internal stability. Things that aren't visible are still there, the feeling of being loved and supported by mother can endure her physical absence, the sense of self-worth that receives no explicit affirmation from the environment can withstand this absence. As with the child energized by a game of peek-a-boo, adults also wonder about the durability of their security, particularly in matters of health (read, life or death). And also like the child playing peek-a-boo, the relief that comes from being notified that a patient is still safe from harm requires constant reassurance.

The difficulty of living with this incredulity is easy to imagine. But living with the alternative—ambivalently accepting the profound indifference that life is capable of showing, reflected in its ending at times that feel totally unrelated to the degree of one’s readiness to die—is also difficult. Preferring safety, most search for people who would save them from the work of making this acknowledgement and facing the despondence that flows from it. Ernest Becker, in *The Denial of Death*, says that when we find those people, we give ourselves over to them all too eagerly, in a way that is related to the psychoanalytic phenomenon of transference (26 p.129). In transference, the adult patient “transfers” to the doctor (in an unconscious psychological maneuver) attributes that he originally ascribed to his parents when he was a child in order to experience them as adequate protection, which, in turn, allowed him to experience himself as adequately protected in and from the world. In this way, transference enables for an adult patient a feeling of relief from anxiety (whatever its stimulus) by distorting (in another unconscious psychological maneuver) the dangerousness of reality to match the wished-for protectedness of childhood. Similarly, according to Becker’s summary of Freud, Ferenczi and Fenichel, when we meet someone, such as a doctor, who taps into what he calls our “secret yearning” to forfeit our will to our parent, we do so, seeking their protection. This yearning, he says, is what fuels our capacity to be hypnotized, as individuals and even as societies. This is so, as Becker explains, “precisely because [we] want to get back to the magical protection, the participation in omnipotence, the ‘oceanic feeling’ that [we] enjoyed when [we] were loved and protected by [our] parents.”* Anna Freud, though, warns that the patient’s transference onto the doctor and the regression to child-like states that animates the transference, is more circumscribed than unbounded terms like “omnipotence” and “oceanic” suggest: “The patient...will do his best to push you [the doctor] into the place of parental authority,” she says in another portion of the speech quoted earlier, “and he will make use of you as parental authority to the utmost.... On the

* Becker p.132, citing Otto Fenichel, “Psychoanalytic Remarks from Fromm’s Book, *Escape from Freedom*,” *Psychoanalytic Review*, 1944, 31: 133-134.

other hand, you must not be tempted to treat him as a child...because he has only gone back to childhood so far as he's ill. He also has another part of his personality which has remained intact, and that part of him will resent it deeply, if you make too much use of your authority." It is difficult to appreciate (sometimes even to believe) the power and universality of transference (in one form or another) and the apparent intolerability of the anxiety that generates it. This is the psychological soil of the doctor-patient encounter, however. The question, *am I okay, Doc?* (read, *will I be spared?*), however inexplicitly it may be asked, is born of that same anxiety about the indifference and dangerousness of the world that motivates the regression to child-like states in the course of enacting a transference fantasy. The part about that anxiety and about that question that deserves special attention is how much hope and hopelessness it holds, simultaneously: that the world will be a more merciful place than we know it to be. We hope for something we know to be unresponsive to hope, trapped in the nonsense of that endeavor. With such deep ambivalence defining the experience of being a patient, studies pertaining to patient satisfaction seem to collude with patients in their denial of ambivalence. They offer, instead, an attractive alternative to living with the deep and often painful feelings associated with profound ambivalence. But doing so reinforces patients' transference fantasy. Without any awareness of these forces, patients may indeed be the center of medical work, but they remain far from the center medical *care*.

4. Ambivalence and what its recognition promises

In the face of such ambivalence, the patient-centered care movement's work to assess patient-satisfaction seems not just superficial, but misguided. Satisfaction measured in any given moment, however genuine, measures something other than what is intended. As the previous discussion explains, urges do seek gratification and when it is attained, satisfaction emerges, but because opposing urges coexist—a fact that forms the basis of ambivalence—the gratification of

one occurs only when another is denied gratification. Our urge to be taken care of is gratified only as our urge to prove ourselves as self-sufficient is denied. Our desire for the help we need is fulfilled only at the expense of our equally powerful desire to not need help. One urge competes with another for expression and gratification. The satisfaction we feel measures our unwillingness to acknowledge the denial of other urges as much as it measures anything else. In particular, the opportunity to deny certain ugly urges (e.g. to hurt or to maim, as Anna Freud suggested, or to rage against the fact of our fragility and the dangerousness of the world we were born into, or to enjoy someone else's misfortune because it means, at least relative to that person's fate, that we have been spared) may contribute to the sense of satisfaction, but this contribution is a function of a deep personal nervousness aimed at preserving a certain fragile, dishonest but more pleasant self-concept, which is hardly the intention of patient-centered care but which is, nevertheless, reinforced in the movement's effort to measure and maximize patient-satisfaction. A more truthful undertaking, acknowledgement of opposing urges and profound anxious ambivalence, does not permit the feeling of satisfaction. Ambivalence is definitively unsatisfying. But allowing its recognition, however unsatisfying it may be for doctor and patient alike, may also be orienting to them both, enabling the feeling of authenticity and self-recognition. This, then, is the second fundamental claim of this thesis: patient-satisfaction is an attractive pursuit for the patient-centered care movement, but it ultimately allows mutually reinforcing self-deception, injury, and alienation to flow between doctor and patient by obscuring the tremendous ambivalence that exists beneath the surface of the encounter. The less immediately gratifying, but more honest-minded work of recognizing this pervasive and inescapable ambivalence, however, breaks this cycle, and enables the arrival at genuinely patient-centered care. The work of this recognition will be the focus of the remainder of this paper.

5. Ambivalence and the call for authenticity

Recognizing the forms and details of ambivalence underlying the doctor-patient encounter requires a self-honesty that ultimately is constitutive of the experience of authenticity. One of the aims of this thesis is to comment on how ensuring authenticity—particularly physician authenticity—serves the purposes of patient-centered care far better than ensuring patient-satisfaction. How authenticity is achieved is a complicated matter, of course, and one route to its achievement will be outlined later in this paper. For now, a brief exploration of what is meant by authenticity may help explain why its attainment is more worthy of attention than patient-satisfaction. In *The Informed Heart: Autonomy in a Mass Age*, psychoanalyst Bruno Bettelheim describes a kind of autonomy that approximates authenticity such that the two concepts or feeling-states, while distinct, are only subtly so.

The continuous balancing and resolving of opposing tendencies within oneself, and between self and society—the ability to do this in keeping with personal values, an enlightened self interest, and the interests of the society one lives in—all these lead to an increasing consciousness of freedom and form the basis for man’s deepening sense of identity, self-respect and inner freedom, in short his autonomy.

One’s sense of identity, the conviction of being a unique individual, with lasting and deeply meaningful relations to a few others; with a particular life history that one has shaped and been shaped by; a respect for one’s work and a pleasure in one’s competence at it; with memories peculiar to one’s personal experience, preferred tasks, tastes, and pleasures—all these are at the heart of man’s autonomous existence. Instead of merely allowing him to conform to the reasonable demands of society without losing his identity, they make it a rewarding experience, quite often a creative one (27 p.72-3).

Consonant with the foundational presupposition of this paper, this statement claims that ambivalence—“opposing tendencies”—is the root of how we experience ourselves, and it is our recognition of that that allows the “continuous balancing and resolving” of these tendencies “...in keeping with personal values” that “form the basis for man’s deepening sense of identity, self-respect and inner freedom.” In this way, it appears that ambivalence prefigures authenticity.

The language of this comment by Bettelheim is worth noting, as well. It inhabits the same territory of self-experience that it describes. The language is careful, but only in its exactness, not in self-consciousness. It is without jargon, and as recognizable as its content is, it feels unobvious and unborrowed—important characteristics of authenticity. These traits carry the

power of the statement to connect, as it does, with its reader. As the reader senses the authenticity in this statement, the feeling that is generated is not so much satisfaction as illumination, identification, and of being addressed, recognized, even animated. The same can be said of another comment of Bettelheim's, also linking autonomy to authenticity, "autonomy...has little to do with what is sometimes called 'rugged individualism'...or noisy self assertion. It has to do with man's inner ability to govern himself, and with a conscientious search for meaning despite the realization that, as far as we know, there is no purpose to one's life. It is a concept that does not imply a revolt against authority qua authority, but rather a quiet acting out of inner conviction, not out of convenience or resentment or because of external persuasion or controls." Here, too, a first-order feeling, as much as thought content, is transmitted to the reader. The generation of spontaneous, personally-peculiar feeling-states is, thus, the focus as much as the derivative of Bettelheim's message. So it is that he stays true to the imperative even as he describes it, a powerful means of underscoring the existential implications of authenticity versus inauthenticity.

On a more technical level, authenticity can be thought of as that which results from the identification and negotiation of profound personal values. Like Bruno Bettelheim, a recent article in the *Journal of Philosophy of Medicine* also sees the concepts of autonomy and authenticity as deeply related, and offers an illuminating, if more abstract, way of understanding the building blocks of the autonomous, authentic experience.

Crucial for understanding the way in which our life over time acquires its structure and shape is the idea of an identity conferring *self-conception* and the *concerns* involved in such a self-conception. An identity conferring self-conception is a description under which a person values himself or herself.... Each self-conception involves a set of concerns.... Concerns are complex wholes of cognitive, affective, and volitional dispositions. They are dispositions to care in a deep sense about particular persons (e.g., your child), goals (e.g., becoming a respected scholar), or ideals (e.g., social justice). Such concerns can give structure and shape to a person's life, as they provide reasons to go on living in a certain way...concerns are the source of the reasons that count for us. ...That we have concerns explains that psychologically speaking we are not just the locus of a flow of experiences.... We can rule ourselves because certain things matter to us profoundly. Therefore, authenticity is a necessary condition for sovereignty. It is a necessary condition for sovereignty because 1. We can only commit ourselves

autonomously (sovereignty) if certain things matter to us profoundly (authenticity), and because 2. Authenticity gives our commitment a unique, identity conferring, content. Autonomy is expressive of who you are. Being autonomous and being *someone* are tightly connected (28).

Autonomy is a familiar value to the patient-centered care movement, but the importance of its kinship with authenticity has not always been recognized. Understanding authenticity in this context illuminates what is at stake when one is inauthentic—nothing less than one’s “being someone.” In the context of the doctor-patient encounter, both actors struggle with authenticity, and as individuals, as much is at stake for one as for the other; afterall, as this article suggests, an obstruction to one’s sense of authenticity threatens one’s very existence. But with respect to the doctor-patient *relationship*, the physician’s professional role obligation to prioritize the patient’s wellbeing above his own places special demands on his capacity to tolerate and contain this struggle. But tolerate and contain it how? The form of this tolerance and containment is undefined. Still, because of his duty to uphold his relationship with his patient, the doctor’s choice of definition has powerful implications, not only for himself, but also (and equally so) for his patient. Exploring the nature of the doctor’s struggle with authenticity and evaluating its impact on patient wellbeing is the focus of the next portion of this thesis.

6. The problem of authenticity

However essential to the enjoyment of authenticity, ambivalence often manifests as conflict—opposing urges that refuse reconciliation compete for gratification. Acknowledging one’s ambivalence is, therefore, often a difficult and unpleasant undertaking. This is particularly so because the opposing urges that await recognition often threaten to reverse the doctor’s hard-won positive self-concept. Consider the common problem presented by a patient who is unlikable to his doctor: an alcoholic patient who, in intoxicated agitation, curses at his doctor; a patient who is continually re-hospitalized for problems related to medication non-compliance

despite his doctor's elaborate efforts to help; a patient admitted for repair of an injury received in the course of wrong-doing; a patient suffering from an infection related to irresponsible behavior; a patient who demands receiving only a portion of a necessary treatment; a patient who is simply demanding, etc. Negative feelings evoked in the course of caring for these patients are virtually unavoidable, but also unavoidable is the threat these feelings pose to the doctor's sense of beneficence. In the name of professionalism, the doctor may attempt to set these feelings aside, suppress them, and treat the patient like any other, but already one can see how his desire to be sensitive is threatened by his desire to become insensitive: however much he may wish to be permeated by the needs of his patients generally, he also wishes to resist permeation by the distaste he holds for this particular patient. The doctor may feel a degree of relief in the organizing principle of professionalism, which by regulating his behavior promises to keep him at a safe distance from feeling and acting upon his distaste. He may thus enjoy momentary safety from a direct encounter with urges related to the distaste that threaten his sense of commitment to the professional norm of beneficence. But he also knows that negative feelings toward a maddening patient are inescapable and believes, moreover, that they are justified. Feelings that he believes are justified on the one hand are, thus, incompatible with the claims of professionalism on the other. The power of the principle of professionalism to force a certain form of doctorly behavior that would have the legitimacy of his feelings be too easily dismissed must, on some level, feel coercive. The safety, though, that such regulated behavior grants him must feel like a relief. He must feel torn, then, wondering if he has paid for his safety with his authenticity, wondering further if this transaction has even succeeded at protecting him from the penetration of these threatening feelings. He may be unconscious of it, but his disappointment in the failure of the professionalism regime that he has been led to believe will protect him from the intensity of the feelings evoked in his work with his patients must be profound. Understandably, he may wish to revoke his commitment to the norms of professionalism and strike out on his own to protect himself where professionalism could not: he avoids the patient he dislikes, or, when

forced to interact, he rejects the patient's attempts to relate by inertly overriding or submitting to patient demands. But doing so must evoke a feeling of betrayal, having forfeited on some level his commitment to the norms of professionalism. The tension between the feelings he has and the feelings he wishes he had must grow, as must the gap between them. To persist in his practice, he has to learn to tolerate this emerging inauthenticity and convince himself that its emergence ultimately serves the patient's wellbeing; afterall, what is the alternative? Acting on his destructive feelings in order to restore his sense of authenticity is unthinkable. This is the problem that authenticity presents to the clinician. While the doctor's experience of authenticity ensures his lasting interest in his patient, it also forces the doctor to face a vast range of self-states, including unpleasant and dangerous ones. Preferring the security of positive self-states, the doctor may deny the existence of these other feelings, thus opening the way to inauthenticity. But while the efforts involved in inauthenticity promise to restrict his range of self-states to those he deems more acceptable, so spent, they leave him too tired and unvital to sustain his interest in his patient.

As much as acting on these feelings in order to preserve authenticity—and thus his vital interest in his patients—is indeed undesirable, often the doctor does so despite himself, as illustrated in the earlier example of the resident's decision to arrest, rather than admit, an assaultive, agitated patient. Denying the existence of hostile feelings seems to work only slightly better than the open enactment of them. Trapped between two bad options, doctors often become disaffected and deeply embattled, as do the patients who bear this outcome. The tremendous effort required to persist amid these unforgiving circumstances, thus, serves neither doctor nor patient.

How then can the doctor be restored to the feeling of authenticity he needs to stay with his patients in the midst of the tremendous and tremendously evocative ambivalence posed by serious illness? One approach to an answer to this question begins with reviewing the literature

on negative feelings aroused in clinicians in the course of their therapeutic work, the subject of this next section.

7. Negative countertransference: when clinicians hate their patients

Pediatrician and child psychoanalyst D.W. Winnicott explored these feelings in a classic article published in 1949, called “Hate in the Counter-Transference” (29). The psychoanalytic concept of counter-transference, related to the concept of transference discussed briefly earlier, is a world of scholarship unto itself. However, for the purposes of its use in this paper, the term can be defined as the feelings and attitudes generated in the clinician (often directed at the patient) in response to feelings and behaviors elaborated by the patient. The patient’s transference stimulates the clinician’s counter-transference, and the interaction between the two forms of transference is the focus of much of the exploration that ultimately yields successful psychological treatment. Indeed, one of the key contributions (30) attributed to this paper of Winnicott’s was the broadening of the conception of counter-transference, such that it be viewed, not as a barrier to treatment as it was traditionally, but as an appropriate and natural response to a patient’s personality that was imminently usable for the purposes of treatment. Winnicott made this claim in the context of recognizing his feeling of hate for a 9 year old boy, whom he met during World War II in a hostel for evacuated children. The boy struggled with problems related to chronic “truancy,” as Winnicott called it. After a failed attempt to treat him at the hostel, Winnicott chose to bring the boy into his home for a second attempt at treatment, lasting 3 months. Referring to himself and his wife, he writes:

We dealt with the first phase [of treatment] by giving him complete freedom and a shilling whenever he went out. He had only to ring up and we fetched him from whatever police station had taken charge of him. Soon the expected changeover occurred—the truancy symptom turned around, and the boy started dramatizing the assault on the inside.... Interpretation had to be made at any minute of day or night, and often the only solution in a crisis was to make the correct interpretation, as if the boy were in analysis. It was the correct interpretation that he valued above everything. The

important thing for the purpose of this paper is the way in which the evolution of the boy's personality engendered hate in me, and what I did about it. Did I hit him? The answer is no, I never hit. But I should have had to have done so if I had not known all about my hate and if I had not let him know about it too. At crises I would take him by bodily strength, and without anger or blame, and put him outside the front door, whatever the weather or the time of day or night. There was a special bell he could ring, and he knew that if he rang it he would be readmitted and no word said about the past. He used this bell as soon as he had recovered from his maniacal attack. The important thing is that each time, just as I put him outside the door, I told him something; I said that what had happened had made me hate him. This was easy because it was so true. I think these words were important from the point of view of his progress, but they were mainly important in enabling me to tolerate the situation without letting out, without losing my temper and every now and again murdering him.... This episode from ordinary life can be used to illustrate the general topic of hate justified in the present; this is to be distinguished from hate that is only justified in another setting but which is tapped by some action of a patient (29).

There are several points worth highlighting here. First, a statement this explicit about the hate a clinician feels for his patient, a feeling generally regarded as anathema to caretaking endeavors, is wholly uncommon and supplies a courageous, successful attempt to open discussion on how to achieve a deeply therapeutic outcome. Its appearance here, as he says, is possible only because he knew all about his hate. In other words, his analysis of the nature of it—that it was born of and applied to the present, and that it was therefore “justified”—enabled a capacity to resist the temptation to disown it, to understand it in its proper context, and thus to use it therapeutically. Second, had he not known all about his hate, he would have felt compelled, as he says, to hit the boy. In other words, his hate, if it were denied, may well have been as destructive as he feared it to be, but made conscious not only did it cease to be destructive, but it began to become constructive, building his tolerance for the situation and thus his continued presence in the treatment. This is the third key claim of this thesis, pertaining to why physician authenticity is so important: it preserves his tolerance for tremendously difficult, often painful and prolonged treatment. When Winnicott writes, “This was easy because it was so true,” he attests to the enjoyment he felt in his acting in a way that felt ‘so true’ to himself. He is proclaiming his authenticity here. That it contributed to what many clinicians have since regarded as an inappropriate enactment of his hate does not diminish the significance of his authenticity enabling

his continued presence—and moreover, his enthusiastic interest—in the life of a child whom he promised to help. This is why authenticity and the enjoyment of it that enables continued presence and deepened interest in a particular patient may provide a critical new focus for patient-centered care.

It is not surprising that Winnicott was heavily criticized for some of what he did to the boy in the name of therapy. However, later clinicians made sure to rescue from the criticism the importance of allowing hatred to come into consciousness, not to force clinicians to recognize their private monstrosity, but to respect the importance of what Winnicott understood could be gained from it. It helped him endure, even embrace, his promise to his patient. Though his missteps were real, so too was his interest in his patient, which must have been quite a gift to a child so acutely sensitive to insincerity. Winnicott believed that the clinician who tolerated the vast range of feelings inevitably provoked in the arduousness of even ordinary patient care would be less stressed by the demands placed on him by his circumstances. He questioned the more traditional strategy of filtering out negative feelings in favor of positive ones, which are more obviously compatible with therapeutic intervention, and explored the possibility that these overtly positive environments actually contributed to patient harm. As Charles Henry recently summarized in a piece that revisited Winnicott's landmark article, the clinician who "remain[s] overly benign and seemingly unaffected by the patient's hostility might be seen by the patient as inauthentic and foolish. Furthermore, being too tolerant and compassionate risks inciting envy about the therapist's 'good nature' and thereby intensifying destructive impulses" (31). Thus, whatever the concerns with Winnicott's management of his own hatred, many authors since have endorsed the notion he introduced, that "countertransference hate is a normal and even necessary aspect of working with certain patients..." (31). This endorsement reflects, at least in part, an appreciation for what Winnicott, himself, admonished in his paper, "However much [the clinician] loves his patients he cannot avoid hating them, and fearing them, and the better he

knows this the less will hate and fear be the motive determining what he does to his patients” (30).

Though explicitly concerned with addressing the uniquely high-pitched fears surrounding clinicians’ hate for their patients, Winnicott’s work also points to the importance of becoming concerned with clinician authenticity, generally. Likewise, Winnicott’s work points to the harms of inauthenticity, as well, reflected in his concern for the environment the clinician establishes for the treatment of his patient. He describes a clinician who too ardently enforces a positive environment in his treatment of a patient grappling with serious illness. The “sentimental environment,” as he refers to this rigidly positive environment, “contains the denial of hate” and as such stunts one’s capacity to tolerate “the full extent of [one’s] own hate” (29). This intolerance inevitably gives way to harm. In a shocking but courageous exploration of hate’s existence even between intimately related interlocutors, Winnicott contends that even mother and baby must cope with the existence of hate and that mother must learn to tolerate it from the earliest moments of the baby’s life. “[T]he mother...hates her infant from the word go,” he writes. He even enumerates 18 reasons why this is so: “The baby is a danger to her body in pregnancy and at birth; the baby is an interference with her private life, a challenge to preoccupation; the baby hurts her nipples even by suckling, which is at first a chewing activity; at first he does not know at all what she does or what she sacrifices for him,” and so on. The purpose of citing this example is to recognize how the sources of hate are often built in, unavoidable; nothing can change the fact that a baby is a danger to his mother’s body in pregnancy and at birth, nothing can make an infant understand the sacrifices his parent makes for him. When Winnicott claims that the clinician cannot help but feel hate for his patient, this is the kind of hate he warns about denying, that he believes must be allowed into consciousness. Hatred, unpleasant as it may seem at first, is built in and, as Winnicott teaches, requires recognition such that its tremendous therapeutic potential (for doctor and patient, mother and baby, alike) is not lost—or worse permitted to devolve into destructive behavior.

Winnicott speculates that mothers tolerate their hate by episodically drawing relief from things like nursery rhymes, famously full of aggressive fantasy. “Perhaps she is helped by some of the nursery rhymes she sings, which her baby enjoys but fortunately does not understand? *Rockabye Baby, on the tree top, When the wind blows the cradle will rock, When the bough breaks the cradle will fall, Down will come baby, cradle and all.* I think of a mother (or father) playing with a small infant; the infant enjoying the play and not knowing that the parent is expressing hate in the words...” (29). This capacity to tolerate negativity, manifest in her capacity to derive relief from confessing it, allows the parent to stay with the baby throughout the time that the baby relies on their continual presence. Furthermore, as with his struggle to treat the 9 year old boy, so Winnicott notes here that tolerance of negativity allows the parent to not inflict harm: “If, for fear of what she may do, she cannot hate appropriately when hurt by her child she must fall back on masochism.” Both the continual presence and the relief of the impulse to harm are powerful outcomes of allowing into awareness feelings as pointedly negative as hate directed at people as vulnerable as a baby. The key point here is that part of what enables beneficence—relief in the conscious experience and careful expression of hate—hardly itself seems compatible with beneficence. This is a deep and difficult claim to trust. And trust alone is not enough. Ultimately, Winnicott reminds us, “...it is important to *study* the ways in which anxiety of psychotic quality and also hate are produced in those who work with severely ill psychiatric patients” (29). While study may only reasonably be expected of psychiatric clinicians, the principle—that more than passing acknowledgement of negative feelings is required to achieve authenticity—holds true for non-psychiatric clinicians with patients suffering from physical illness, as well. “Only in this way,” he continues, “can there be any hope of the avoidance of therapy that is adapted to the needs of the [clinician] rather than to the needs of the patient.”*

* In fact, he goes so far as to say that the clinician must admit his earlier feelings of hate for his patient before an analysis can be considered complete; otherwise the patient is never retrieved from the infantilized state enabled and utilized in the course of the analysis.

There are many other therapeutic uses of hate explored in the psychoanalytic literature on negative countertransference. But however much distaste a particular patient's personality or story may evoke in the physician, it is important to recognize that the doctor-patient encounter, all by itself, is equally evocative: the very fact of the patient's neediness, the expectation he has for energetic doctoring, the intrusiveness of even reasonable demands. Even more deeply evocative are the many realities that attenuate patient gratitude: that the doctor might not cure him, that material mistakes may be made, that he must make his way through his illness in the company of a clinician whose health is a constant reminder of his tragic and tragically lonely fate. Each of these claims is built in to every doctor-patient encounter, even those with a healthy or recovering patient. The arousal of distaste, given the force of these claims, is also inevitable. But the ethos of suppression, however often it fails both doctor and patient, is strong. It is easy to imagine a well-intentioned physician springing to work to ease the pains just enumerated, recasting them in a more positive light: as a privilege, for example, to be entrusted with his patient's care. But this is the 'sentimental environment' that Winnicott warned is so dangerous. It is also easy to imagine a physician who has become tired with how unending this work is, how insatiable patients seem to be, irrespective of his efforts. Pursuing the heroic standards of professionalism, often reinforced by the wish for heroics issued by their patients, doctors often set out on the impossible task of salving pains that ultimately cannot be salved. As long as human beings occupy the role of physician, for example, mistakes will be made. While mechanizing medicine may address the number of mistakes made and thus make a valuable contribution, it will do nothing to protect patients from the anxiety underlying their demand for fewer mistakes. Ultimately, it is not human fallibility but human frailty that worries patients so profoundly: one little mistake and their frailty manifests in a way that is often terrifying. Indeed, these inescapable realities are as frightening to doctors as they are to patients, and their interest in distracting themselves from them is often equally intense. This is the trigger to doctor inauthenticity that distorts the doctor's relationship

with himself, threatens his sense of professional commitment, and eventually even threatens to harm his patients.

The construction of inert environments often results from the doctor's pursuit of safety from the turmoil of disease intervention. But in his article, *Hatred and Its Rewards*, psychoanalyst Glen Gabbard notes another reason why a clinician might seek to provide a 'sentimental environment,' in which the clinician appears easy and unaffected by the patient's turmoil (32). In establishing such an environment, he hypothesizes, the clinician may be interested in serving his unconscious sadism—his wish to harm, as Anna Freud might say—delivered in the intensification of shame and self-criticism that the environment produces in the patient, whose emotional impotence is thus laid bare. Thus, such environments may reflect either doctors' fear and flight or anger and aggression, both stemming from an anxious need to overcome the claims of negative feeling-states. In a powerful passage referring to his patients, Gabbard speculates about the uses of hate feelings in a way that seems equally descriptive of what many doctors experience.

I have often wondered why these patients cling so tenaciously to hated internal objects and hating self-representations when their lives are eaten up with bitterness. Their sense of being wronged is so pervasive that forgiveness is out of the question. When one analyzes these patients for long periods of time, one learns that a hateful relationship is better than none at all. ...As [other authors have] also noted, the patient's identity may be organized around hatred, and the modification of the hating self-representation or of the hated object representation is often experienced as a form of annihilation. The patient may preserve a sense of meaning by hating, and change may cause the patient to confront a sense of living in a meaningless state. As psychoanalysts, we too often underestimate the importance of existential issues such as having a reason to live (32).

It may sound extreme, but if 'doctor' were substituted for each mention of 'patient' in this passage, something true comes through, something that physicians easily sense in one another and that many patients sense in physicians, as well. For many doctors, 'their sense of being wronged' comes from their sense that their role as professional has failed to protect them from unwanted self-states. And, as injuries attributable to the inadequacies of the professional role accumulate, many doctors do indeed develop an 'identity organized around hate,' in one form or

another. However unconfessed, many physicians recoil with the need to attend to another hospital admission. This resistant posture can and often does become a fixed part of the physician's identity. Thus, feeling wronged by but beholden to the norms of professionalism and unconvinced that his feelings towards his patients need as much editing as professionalism demands, doctors often become hardened victims of their own sense of betrayal—betrayal of their authenticity in deference to their unsteady commitment to professionalism and betrayal of their loyalty to professionalism in pursuit of restored authenticity. Ultimately, however, the flight from this troubled psychological territory to the relative peace of fixed attitudinal states, as Gabbard suggests, often yields anything but this much-wished-for peace. Instead, it often animates in the doctor new and deeper forms of distress: a sense of feelinglessness, loss of feeling alive, meaninglessness, and eventually even the loss of 'a reason to live' in the lives of his patients.

8. The preference for false conflict and a way through it

What then should be done? If the premise is accepted that patients depend on and deserve optimal physician functioning and that inauthenticity threatens physicians' ability to function optimally, then the question is how to restore doctors' sense of authenticity when that authenticity contains the normal range of human feelings, including many that seem to threaten patient care.

In answer to this question, this thesis suggests that these feelings, far from requiring suppression, need to have a role in the care of the patients they are thought to threaten, if the doctors who have them are to be restored to themselves. The nature of that role may be best understood in the context of an example: consider an elderly patient who has recently suffered a massive stroke and who has entered a coma. The healthcare team determines that interventions are medically futile. Because the patient is unable to issue demands himself, and because in this case the patient has no prior documentation of his wishes, the demands of the patient's family will stand in for those of the patient. Soon after the physician has shared with the family the

patient's bleak prognosis, the patient develops an infection, and the family requests its treatment. The physician sympathizes with the family's pain, but he also feels obligated to protect the patient from the potential harm of futile treatment.

The traditional debate around medical futility has explored from a number of perspectives the doctor's obligation to treat this patient. From one perspective, the obligation hinges on the definition of medical futility. Lawrence J. Schneiderman et. al. argued that a physician could reasonably deem a form of treatment futile if that treatment indeed proved futile in the last 100 similar cases, gathered from personal experience, colleagues' experience, and experiences reported in the literature (33). From this perspective, if the doctor deems that the treatment is futile, then he has no obligation to supply it.

Another perspective on this question suspends the task of defining medical futility and instead seeks consensus among clinicians pertaining to a level of suspicion that could justify pronouncing a particular treatment futile (34). From this perspective, if the doctor feels a certain threshold of suspicion has been met that treatment is futile, then he is justified in denying the family's request.

A third perspective on this question hinges on the priority assigned to relevant professional principles. Some have argued that physician autonomy is the key principle at stake, warning that even principled deference to the patient's right to self-determination risks dissolving the physician's moral agency. Others have countered that the principle of patient self-determination is most important, stating that whatever their interest in professional autonomy, doctors' ultimate professional duty is to subordinate their own interests to those of their patients. In this case, if the doctor prioritizes physician autonomy over other relevant principles and he believes that his patient's interests are not well served by delivering treatment, then again he is justified in withholding it.

From each of these perspectives it would seem that the doctor is justified in not treating the patient, despite the family's plea. The question of the doctor's obligation has been

answered—but does the situation really feel resolved? The plea still stands, and something inside the doctor feels wrong ignoring its force. Should the doctor maintain his conclusion not to treat and ignore his misgivings? Or should he allow his sympathy for the family to override his sense that further treatment may harm the patient? What should he do to respond to these competing claims? Invoking the principles of professionalism gives no good answer here. Under the pressure of his patient's looming death and the family's growing anguish, the doctor feels deeply torn, overwhelmed by the urgency of the opposing claims and abandoned by the promise of the professional role to protect him. He anxiously seeks protection from another source and considers a battery of options that he knows, on some level, are inadequate: to just do what the family requests, or hold fast to his decision to withhold treatment and ignore the family's request, to avoid contact with the family while doing so, to avoid contact with his colleagues who might judge him for his stance, etc. It is plausible that he might even feel quite resentful here, thinking, 'I hate having to choose between two things that I think are equally important. Either way I choose, I'm wrong. Either way, I end up the bad guy. I hate being put in this position, and I hate them all for putting me in it.' But what is his alternative to acting on these obvious breaches of professional norms, when professional norms have failed to fulfill the promise he believed they made to him? Then again, if he indulges these breaches, what standing will he have with his sense of professional commitment? Who will he have become? Self-estrangement seems to be the only certain outcome.

This is the key moment, when inauthenticity can overtake authenticity. But what if the doctor paused here, and so paused, what if he recognized the disorientation reflected in his anxious consideration of equally undesirable options—protecting the patient but ignoring the family, or taking mercy on the family and putting a critically ill patient at further risk. He may have previously looked at such decisions and thought, 'These are the difficult decisions that one must face in medicine. And it's what makes medicine so special.' But this is the sentimental environment that 'contains the denial of hate' that Winnicott warned about. If, instead, he let his

sense crystallize that ‘something still feels wrong,’ even after the algorithm has been processed and the decision has been made, maybe he would realize that it is not a difficult decision that he faces, but a fake one, between two wrong answers. What is difficult is confronting what drives the production of a fake decision: the awful truth that whether or not the patient’s infection is treated, an unnegotiated, unnegotiable loss will happen, and that the pain in the family’s request is cannot be salved. There is an injury in recognizing this truth, and it hurts everyone who feels involved in the decision. If he suppresses the acknowledgment of this injury, it will have the chance to deepen, and as similar injuries from similar encounters accumulate, it will likely give way, as chronic injuries do, to a loss of function. But maybe the doctor would feel some relief in letting the truth come in, in recognizing that his unedited reactions, such as his quiet sense that something still feels wrong, can actually be useful, not threatening. These reactions can point to important discoveries about the real problem (i.e., how to live with unchangeable and awful truths) that underlies the stated one (i.e., to treat or not to treat). In other words, not only would his reactions not require immediate processing by the clumsy hands of professionalism, but they could come forward, take shape, and become altogether important in the guidance they could provide. This would bring the doctor back into himself, to rediscover his easily exiled sense of authenticity.

But what would this rediscovery really accomplish? What is the significance of the restoration of physician authenticity, beyond the obvious significance that it holds for the physician? This thesis contends that many important consequences follow. It starts with the opening of the possibility that the doctor might feel less isolated from himself and others, and thus less reluctant to present concerns to his colleagues and seek their counsel. More supported and richer for the counsel, maybe the doctor would feel more interested in and more capable of opening up difficult discussions with his patient or patient’s family. Many other questions will certainly arise in the course of these difficult discussions, but maybe so self-possessed, he would be less likely to become ensnared in conflicts composed of false constructs, such as choosing

which arbitrary standard for medical futility to apply—a certain degree of statistical remoteness for recovery, medical community consensus on a standard, or moral hierarchy imposed upon equally important principles. When he is trapped in the feeling of having lost his bearings, when he has lost himself to inauthenticity, this is exactly what happens—he seeks an algorithm that will regulate his behavior, organize his thoughts, and relieve him of the burden of figuring out how to respond to the agony that lies in the family’s request to treat a patient who has no chance of recovery; so guided, he can withhold treatment and reject the family’s desperate request, comforted that the source of the rejection is an external algorithm. Restored to authenticity, though, his uneasiness about the adequacy of this logic could blossom and an interest in directing his attentions to a more honest assessment of the problem could evolve.

Thus, while the doctor’s restoration to a sense of authenticity clearly benefits the doctor before it benefits anyone else, it later benefits everyone else, the patient and the patient’s family, and it does so in a way that almost no other medical act can. It secures the doctor’s presence, interest, and best judgment, and thus safeguards his patient from abandonment, indifference and misguidance. There is, of course, no guaranteed outcome to a doctor-patient relationship premised on restored physician authenticity. But so restored, other lost truths can be rediscovered, as well—such as the total *inadequacy* of the proposed standards for medical futility or the existence of equally important principles of professionalism that *cannot* simultaneously be honored and the *unacceptability* of the requirement to sacrifice one if either is to be fulfilled. It is possible that this rediscovery will encourage compromise, at least from the doctor, where previously none seemed available; the choice was presented as either-or and the principles reflected in each were incompatible. But once the doctor admits to himself how forced it feels to prioritize one principle over another, their moral equality can be recognized. With this recognition, the opportunity for compromise is revealed, as is the realization that refusing to

compromise suggests a moral hierarchy where there is none.* Thus, the question whether or not to treat a dying patient whose family begs for treatment, need not be answered by a deeply divided doctor whose misgivings persist with either choice and whose capacity to make such a choice requires a flight to an inauthentic self that leaves the patient and his family out of the decision; rather, the question can be *opened* into a discussion aimed at tearing down the false premise of the conflict, building the good faith that comes from authentic engagement, and discovering a mutually agreeable compromise.

This rereading of how to approach the question of medically futile treatment requested by a desperate family illuminates the relevance of Winnicott's sense of countertransference. The doctor, in this case, may feel squeezed by the choice of two terrible options, one exploiting the patient's vulnerability, the other exploiting that of the family. If the doctor is already estranged from himself (i.e., operating inauthentically) when he reads this choice, he will be unable to see its false premise. The anger he might feel at what he knows will be the implication of his choice—that he chose wrong, no matter which option he decided upon—is imminently understandable. To the extent that his anxiety about this implication is unrecognized, though, it triggers an almost instantaneous flight from self. Thus, the tremendous benefits of recognizing one's hate toward one's patient or patient's family, which Winnicott regarded as essential to appropriate patient care, is quickly hidden from the doctor's view behind the inauthentic claims he uses to protect himself (e.g., 'The family was being unreasonable, so I feel good about the difficult decision I made to protect the patient,' or 'I didn't want to be the one to take the family's hope away, so I treated the patient and let nature take its course,' etc.). So lost to himself, the danger that Winnicott identified in 1949 is realized: the treatment plan the doctor pursues now aims at self-protection, not patient care. This is the loss of patient-centeredness wrought by physician inauthenticity. And this is also why even non-psychiatric doctors must beware of

*A closely related and more elaborate discussion of the appropriate approach to such conflicts can be explored in Burt, R.A. 2002. The medical futility debate: patient choice, physician obligation, and end-of-life care. *J Palliat Med* 5:249-254.

negative countertransference: its denial violates their authenticity and advances self-protection instead of patient-care.

There are important benefits to this approach to the turmoil inherent in the care of patients, but believing in these benefits does not make the work of the approach easy. The importance of the work, though, can be seen from what happens to doctors when they avoid it: they feel lost in the challenges they often face and, when disabled by this feeling, they begin to become lost to themselves. Over time, this process yields in the physician a feeling of being uninvested, despite his professional aims. The collateral harms of operating outside of oneself, the harms of one's inauthenticity, accumulate, and the sense of having somehow disappointed oneself gives way cynicism. Doctors need to be protected from these harms if they are to be able to survive the turmoil of patient care and stay invested in their patients who need them. This is what patient-centered care requires. In the earlier portions of this paper, we saw how the patient-centered care movement has preferred to pursue patient-satisfaction as the measure of patient-centeredness. But however outwardly well-matched these variables seem to be, beneath the surface their profound and dangerous mismatch is apparent. The goal of patient-centered medicine is not a satisfied patient who is blind to the basis of his/her satisfaction. Neither is the goal to replace the exaggerated moral authority of physicians with that of patients. But this is where the pursuit of patient-satisfaction leads. It is the wrong paradigm for patient-centered care. Its casualties are the doctors who hide in it and the patients who rely on the care they issue from this regrettable hiding place.

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